Regional Workgroup Minutes

Meeting #4
October 11, 2011, 9:30 am to 3:15 pm
Iowa State Capitol, Senate Committee Room 22
1007 Grand Avenue, Des Moines, IA

MINUTES

Attendance

Workgroup Members: Jane Arnold, Robert Brownell, Mary Chavez, Tom Eachus, Lori Elam, Jack Guenthner, Donna Harvey, David Hudson, Sarah Kaufman, Linda Langston, Bob Lincoln, Charles Palmer (Chair), Sally Stutsman, Mary Vavroch (Co-chair), Suzanne Watson, and Jack Willey.

Legislative Representation: Renee Schulte, State Representative, House District 37 (Linn County) and Co-chair of the Legislative Interim Committee on MHDS Redesign; Jack Hatch, State Senator, District 33 (Polk County) and Co-chair of the Legislative Interim Committee on MHDS Redesign; Joe Bolkcom, State Senator, District 39 (Johnson County) and member of the Legislative Interim Committee on MHDS Redesign; Amanda Ragan, State Senator, District 7 (Cerro Gordo County) and member of the Legislative Interim Committee on MHDS Redesign

Facilitator: Steve Day, Technical Assistance Collaborative (TAC)

DHS Staff: Theresa Armstrong, Connie Fanselow, Julie Jetter, Deb Johnson, Rick Shults, Brian Wines

Other Attendees:

Bob Bacon	Center for Disabilities and Development (CDD)
Kris Bell	Senate Democratic Caucus
Joshua Bronsink	Senate Republican Caucus
Dawn Clark	Wapello County Social Worker
Diane Diamond	DHS Targeted Case Management
Glenda Farrier	CASS Incorporated
Linda Hinton	Iowa State Association of Counties (ISAC)
Sandi Hurtado-Peters	Department of Management (DOM)
Ken Hyndman	Des Moines County CPC Administrator
Kathleen Jordan	DHS Target Case Management
Sheila Kobliska	Chickasaw and Mitchell Counties

Other Attendees (continued):

Gretchen Kraemer	Attorney General's Office
Brice Oakley	Iowa Alliance of CMHCs
Kelley Pennington	Magellan Health
John Pollak	Legislative Services Agency (LSA)
Ann Riley	Center for Disabilities and Development (CDD)
Jean Rommes	Heartland Management Alliance
Joe Sample	Iowa Department on Aging (IDA)
Kim Scorza	Seasons Center
Patrick Schmitz	Plains Area Mental Health Center/IACP/IACMHC Alliance
Deborah Schultz	Jones County
Rik Shannon	Iowa Developmental Disabilities Council
Julie Smith	Iowa Health System
Chris Sparks	Exceptional Persons Inc.
Karen Walters-Crammond	Polk County Health Services
Ryanne Wood	Lee County CPC Administrator

Agenda

- Introductory remarks
- Review of Meeting #3
- Recap of Discussion on funds pooling and county role in governance
- Group discussion of performance indicators for regions
- Group discussion of the pathways to establish regions
- Group discussion of the roles of regions in the management of Medicaid Home and Community Based Services
- Wrap up and homework for next meeting
- Public Comment

Meeting handouts:

- Agenda
- TAC discussion paper on (a) pathways to forming regional entities; and (b) management/oversight functions necessary to assure high quality, equitable and consistent management of Medicaid HCBS services throughout Iowa.
- Examples of performance measures currently used by counties.

Key Questions for Workgroup to Consider:

- How can county commitment to and support of regional structures be assured?
- What are the minimum performance expectations and thresholds to have a contract with DHS for regional management of MH and ID services?
- What is the maximum amount of regionally-managed resources that may be used for administration as opposed to direct services (as measured by payments to providers)?
- What roles should regions play in statewide activities such as best practice implementation and workforce development?

- Under what circumstances will or must the state (DHS/IME) exercise second level approval of service eligibility and authorization decisions (e.g., certain HCBS waiver plans)?

INTRODUCTORY REMARKS

- Rep. Schulte, Senator Bolkcom, and Senator Hatch welcomed members and guests and indicated their interest in listening to the discussion.
- Steve day introduced the agenda for the 4th meeting of Regional Group.
    - There will be one more full meeting before the preliminary recommendations are formulated to submit to the Interim Committee.
    - Today the group will revisit issues where consensus has not been reached.
    - And will discuss the performance indicators for regions, the pathways to forming regions, and the role of regions in managing Medicaid services.

REMARKS BY SARAH KAUFMAN

A few points for the workgroup to consider:

- Have not had much conversation about the potential cost of the new system or estimates of the resources available.
- Counties don't need to contract with the state to spend their own resources.
- When we talk about regions contracting with the state, we are talking about a state run system.
- It isn't clear where the Interim Committee will be getting the information to consider in making resource decisions.
- If funding isn't sufficient the redesign work, our work has the potential to be irrelevant.
- Have not heard discussion about the state's level of accountability in the new system or the regions' recourse in holding the state accountable.
- If this is to be a partnership, the accountability of both the state and regional partners should be addressed.
- The counties have endured cost shifting, unfunded mandates, and reduction of promised funds.
- Regions will need to have some buffer from the issue of waiting lists for populations that will be the state's funding responsibility.
- Providers need to have a buffer from the issue of the state freezing and reducing rates.
- If rates are based on approved cost reports, then they should not be reduced as a form of cost containment.
- We have been provided templates for developing regional management plans and annual reports that are used by counties in the current system.
- These are the same tools that have been attributed to a "broken" county system.
- There seem to be attempts to make the county system appear to be a bad system and it is not.
- Counties currently submit annual reports that are supposed to be a tool for state oversight.

- No useful feedback is provided to counties, and it does not appear that the data from those reports is pulled into useful information about the system at the state level.
- About three years ago, the State Auditor's Office reviewed 20 to 25 counties and it is my understanding no major deficiencies were identified.
- The final report of those audits should be shared with the workgroups, DHS, county boards of supervisors, and legislators.
- I don't think that county supervisors necessarily support regionalization.
- We need to consider these things other than just the template of a plan.

REMARKS BY JACK GUENTHNER

Clarifications regarding the Meeting 4 Discussion Paper:

- Page 8 indicates a regional population range of 250,000 to 500,000
- 200,000 to 700,000 were the regional population numbers the group agreed upon.
- The group also reached consensus on 5 to 15 regions and not less than 3 counties per region.

RECAP OF MEETING THREE

At the last meeting the group was close to consensus on funds pooling and governance:

- Different approaches were discussed for funds pooling:
  - Pooling funds in one account (actual pooling).
  - Funds remaining in separate county accounts but being spent according to an agreed upon unified plan (virtual pooling).
- The objective is to adopt a system with the least amount of occurrences where funds have to move back and forth (reduce transactional frictions)
- Actual pooling better meets the test of reducing transactional frictions
- A pooled account could be viewed as a "joint checking account" where funds go into the same account but are tracked in a way that each county can individually account for how their share of the funds are expended.
- Funds allocated to each member of the regional group are shown through financial reporting.

GROUP DISCUSSION

- The possibility of a region becoming the fiscal agent through a 28E agreement was also discussed.
- Is a region a consortium of counties so the entities are really the counties, or does the region become a new organization that is the managing entity?
- The CSS (County Social Services) currently functions as a consortium of counties.
- The legislature could determine the requirements for the 28E agreements to form regions.
- Chapter 28E allows counties to work together or with private entities or allows them to form new entities; a decision would need to be made whether one or the other or either option is allowed for this purpose.
- It is going to be more of a challenge to absorb the transition from legal settlement if funds are pooled; some counties will have significant increases in liability and

some will have significant decreases in liability in changing from legal settlement to residency.

- We want to make sure we don't create a residency system that causes the same problems as legal settlement.
- How will residency be used?
- To the extent there are county levy funds that will be contributed to regional, it makes the most sense that they are contributed to a shared account with accounting system to track and provide accountability to each member.
- It does not decrease transactional friction to keep funds separate.
- The transactional friction piece is already in the process of being resolved through the CSN (Community Service Network).
- One of the values is local coordination and the ability to tap into local resources.
- We want to try to reach a model where funds can be pooled and how money comes into the account and how it goes out of account can be tracked.
- As it stands now, the county mental health levy goes away July 2013; will the legislature be looking at restoring some type of mental health levy?

Response from Senator Hatch:

- There is a belief on the Democratic side that there needs to be county dollars into the program for stability.
- It is left open how that money would be coming in; it could be a county levy, a general fund, or it could come in as county money and flow through the state.
- The conclusion has been that the cost of mental health care is only going to increase and we need to have a system that coordinates services.
- I think the legislature will be embracing some sort of county contribution.

Response from Representative Schulte:

- The county piece is only 10% of the whole picture.
- We want to get mental health to the point that it is on equal footing with education and other programs that receive stable funding every year. That is the goal.
- I don't see how we will get there without some county funding in the initial years until that stability can be established.
- We can look at other choices besides property tax. It will be a process to transition to something different.

Response from Chuck Palmer:

- The legislation that passed asked us to sit down as a group and try to figure out how to make this happen. We need to do that.
- Because of loss of federal stimulus money and the increase in Medicaid match, we are starting at $50 to $60 million below the status quo.
- Even in the last years, discussion of "buying out" counties was seen as a process over time.
- On a practical basis, I would make the assumption that there is still going to be county dollars in the system.
- It is imperative on us to put together the best plan on how to use the funds available and make it work within a regional structure.

- Between the time we make the preliminary recommendations and the final report, we will be pricing out the recommendations so that the final report will have a price tag for legislators to work with.

General recommendation:

- Regions should have a shared funds account with detailed reporting back to counties.
- There still needs to be flexibility in negotiating with providers on rates and activities.

Counties forming themselves into regions can adopt different forms of organization:

- Can be a consortium of counties or can designate a single entity under 28E.
- Either option can be allowed at the discretion of the members of the region.
- Don't want to create extra costs.
- Need some consistency to measure efficiencies, but some flexibility.
- Who will be the decision maker at the table in a consortium?
- What do you do about a disparity of pay and benefits between counties?
- The CSS group initially tried to become a separate entity and realized that they were duplicating administrative structure to do that.

Point of Accountability:

- Where does accountability sit?
- What is the relationship between the state and the region?
- Accountability is between the region and state, not the region and county.
- The concept of a single point of accountability is the most critical thing.
- The state entity that is responsible for seeing that public dollars are spent needs to know there is a central point of accountability, by contract or other means.
- The region has to hold itself and its members accountable.
- The regions could "hire out" functions such as bill paying, IT, etc.
- They could not give up having a single point of accountability.

Role of CPCs:

- Does having a regional administrator mean getting rid of county CPCs?
- The region would have to designate the person to be administrator. That would change the functions of others who had been doing that for their individual county, but those people might continue to serve other functions such as local point of contact.
- The law eliminates CPCs as of July 2013. There is a need to address how their functions will continue to be carried out.
- People can be absorbed and reassigned according to their talents. There is much work to be done.

GROUP DISCUSSION OF PARTICIPATION ON GOVERNANCE BOARDS AND ADVISORY BODIES

- Should there be consumer and family representation on governance boards?
- How should providers have representation?
- Steve Day recommended providers are not included on governance boards but should have opportunity for regular input.
- It would be problematic to have providers as payees on the governance board, which has fiscal control.
- Could specify that each region must have a consumer and family advisor group and a provider group.
- If counties are contributing funding, the governance group should be elected officials or representatives.
- Could have consumer members if elected have the majority.
- Support “one county, one vote” structure.
- Need to allow for variance in size of bodies and size of regions.
- Having consumer voices would be beneficial in governance
- It is critical to have supervisors for financial accountability.
- Governance group size may be a challenge for regions of many counties.
- From the consumer perspective, consumer advisory councils can become token and no one listens to what they say.
- Johnson County has had a strong planning council presence including supervisors, providers, and consumers. They review budgets and make recommendations but the buck stops with the supervisors.
- Providers should be advisory.
- Not having providers at the table will result in missing a lot of efficiencies that could be brought to an integrated model.
- Advisory bodies can be full participants and make recommendations.
- Supervisors ultimately have to be the ones in control and accountable for the final spending decisions.
- Advisory committees can be very integrated into the process.
- The functions of the governance group should be discussed first, and then the membership to carry out those functions.
- Allow regions flexibility in how to meet functions.
- The principle of mixing payers and payees is not a good practice.
- Supervisors or designees (elected officials) need to have a majority vote.

Consumer and family participation:

- Consumer and family voice is extremely important to the process and also extremely difficult to get.
- It has worked best in places where there is a moral or statutory mandate and a real commitment. It could be a performance measure for regions.
- If it is not required, it probably won’t happen.
- If we are going to be true to Olmstead, consumers ought to be part of the decision making group.
- Systems that do include consumers and family members do get better.
- If that is so, we should not be permissive about including consumers.

- Recommend that a consumer member is mandated.
- Very important providers have a voice, not the decision making power.
- If decision makers are going to be supervisors, they must be kept very well informed about services, how things are going, what is needed.
- There should be some sort of consumer and provider planning group that governing board is a part of.
- Require that governance board members show up and hear from people.
- The Office of Consumer Affairs has an advisory board in each DHS region. That would be one way for decision makers out what consumers are thinking.
- Family members and consumers are members of the MHDS Commission and they play a vital role in making decisions and having well rounded discussion.
- It is important to give consumers information they can use. For example, identify acronyms, and not communicate in jargon.
- Support the idea of a performance measure for consumer participation.
- It takes a real effort to make sure consumers are included in a meaningful way.
- Suggest a minimum of three consumers on governance board but it could be more depending on the size of the board.

Provider participation:

- A medical home and integrated model makes the role of the provider important.
- Don't think you can have providers as payees being voting members on a governance board.
- The region would not be the affordable care organization. They would be the payer or the certifier of the affordable care organization.

Recommendations:

- Regions must state how they are going to include consumers and families in their business, especially in quality assurance and outcome measures.
- Each region must address how they are going to include providers and other stakeholders in the process.

Are there some situations where there needs to be weighted or proportional voting based on population or dollars?

- In general one county, one vote makes sense for an equitable approach.
- All counties, large and small, have a direct stake and commitment in the care of their citizens.
- Are they specific circumstances where it would not be equitable?
- Could envision that a large county in a hub might want to implement "core-plus" services and smaller counties would not.
- Those things could be worked out in the relationships between the members of the region.
- Flexibility is key.
- Support one vote one county.
- Need to operate on good faith.
- Group consensus is "one county, one vote".

What specificity should go into the statutory framework?
What should be put into administrative rules and program guidance?

- Think about “core” and “core-plus” in the context of implementation over time.
- We do not want to take down a quality set of services in one county to bring up services in another.
- What is the initial core?
- What can be prioritized as new money is available?
- Think through the possible strategies.
- Other Workgroups are defining core services and prioritizing which ones make the most sense to start first.
- How will a grievance of a county within a region be handled?
- Just as there is a grievance and an appeal process for consumers, we need a process for members within the region itself.
- Should specifying a dispute resolution process be a required part of the 28E agreement?
- If there is an impending “break up” of a region, does the state have the authority to step in?
- Is it the voters at large or the supervisors who make those decisions?

GROUP DISCUSSION OF PERFORMANCE INDICATORS FOR REGIONS

- The discussion paper includes a chart of possible indicators for review.
- Members also received a list of performance indictors that are currently being used in various aspects of MH/DD services.
- Other workgroups are looking at performance measures that relate to consumer and family outcomes.
- How do you use this information to drive the system toward better quality over time?
- The Linn County report has good examples of how performance indicators are used (see page 43). They have interpreted the data for qualitative purposes and identified places where they did not meet expectations.
- Polk County also has a pretty sophisticated way of using outcome and performance measures.
- We want to move to a place where you are using this info for qualify assurance and quality improvement.
- Page 7 of the performance measures handout shows examples of the kinds of measures that are typically collected in systems of managed care.
- They include process measures of how well people get linked to care, don’t fall through cracks, avoiding adverse events in their lives, etc.
- Things that would commonly be measured in a performance based contract.
- The actual indicators that are going to be used in the first year or two are probably going to have to be determined later in the process. It makes sense for this group to determine general domains.
- If key performance measures are going to work, there has to be some degree of autonomy for the region.

- There has to be a strategic plan that is aspirational for the region that the performance measures are linked to.
- There needs to be a standard set of threshold measures that everyone agrees on.
- In the first couple of years, there may be a big focus on just getting the data right.
- The central obligation is to be transparent.
- After recommendations come from other groups for consumer and family performance indicators, there needs to be a process for standardizing.
- Recommend using indicators that can be derived from data that is already collected and that does not require more work than is being done now.
- It does require some staff expertise to do it well.
- Collecting performance data is less of an administrative burden because people are not called upon to produce special reports and analysis to answer every questions that arises.
- Data is reported and interpreted on a regular basis and everyone has access to it.
- There is a danger of asking for too much information.
- Probably focus on about 10 indicators that are really important.

Comments by Bob Lincoln on the Functions of Regions:

- One of the opportunities we have in designating what the region does is in the role of service coordination.
- We have an opportunity to look at the role of advocates who work hard to connect people with services (in outpatient commitments).
- If regions could hire advocates to do that, and essentially make case management/care coordination a component of the commitment, it would be a real value added.
- Regions should take a primary role in service coordination, as an access point.
- It takes a while for a request for disability services to reach the point of assessment. The regional access point could be an opportunity to review people for minimum criteria for waiver eligibility (rather than sitting on waiting lists for services that they will not be found eligible to receive).
- Providing initial assessments, triage.
- Crisis stabilization services should be offered.
- Jail diversion should be part of it.
- Hope we will allow regions to provide or designate/contract for case management and provide access points.
- Guardianship and substitute decision making. Opportunity for county to interface with county attorney's office. Should start at a basic level and build on that.
- In outpatient civil commitment, the person is committed to a doctor, not an agency. There is very little coordination; opportunity for regions to provide some designation and coordination.

- Opportunities to integrate other mandates such as detox, substance abuse, Oakdale, Toledo, non-state shelter care, general assistance.
- It would be nice to have a more formal assigned role in MFP (Money Follows the Person); could help drive that process.
- Explore how regions can leverage or use institutional beds for non-Medicaid eligible people.

Bob will submit a list of his comments for this and other workgroups to consider. You can find his comments at:
http://www.dhs.state.ia.us/docs/Additional_Specific_Functions_for_Regions_From_Bob_Lincoln.pdf

PUBLIC COMMENT

Comment:	I have heard references to a "global budget" inferring that regions would have a role in all services provided. Is that correct?
DHS Response:	The reference to "global" was in regard to county levy and other funding steams that flow to counties.
Follow-up:	Does that make sense in what we are talking about the region defining from a service perspective?
DHS Response:	That is clear for non-Medicaid funded services but not clear about Medicaid funded services. If it is a broader approach we may need to look at representation from state legislators and others.

PATHWAYS TOWARD FORMATION OF REGIONS

- How much is dependent on counties coming together voluntarily?
- How much is directed or mandatory?
- Key issue is time constraints. The time for getting regions up and working is short.
- Handout lays out the pros and cons of how to approach forming regions.
- The statutory framework will become clearer over the next few months.
- How will we deal with the exceptions?
- What happens to counties that aren't linked up with anybody and don't seem to go naturally into a group?
- How much discretion or authority will the state have to make regions happen?
- What is the alternative to voluntary formation?
- It is not going to be possible to let a lot of time elapse before regions are formed.

State should have the authority to step in:

- To assign "orphan" counties?
- To meet deadlines?
- If something goes wrong and can't be fixed internally?
- If a region no longer meets the established criteria?

- If a receivership is needed?

Formation of regions:

- It will be important for regions to form quickly so there is time to come together and process how to work through the details.
- Are there other options than regional administration?
- There is concern about having regional lines for the delivery of services and creating the same problem as legal settlement with different boundary lines.
- What changes at the county level?
- What are the substantive changes in what counties will do?
- Regions would not have to perform all the business functions themselves. That could be done in a variety of ways.
- There are opportunities for administrative savings in processing claims, etc.
- Need more consistency on the provider payment side. Rates need to be set in a consistent way.
- One thing CPCs do now is verify the veracity of the invoices that come in. That is an important function of the region that still needs to happen on the local level.
- If the state is going to handle the financial side of it, and the bills are not verified, there is much room for error or abuse.
- From a provider's perspective, I would rather be able to talk to someone who knows what the services mean; a local "go to" person.
- Want statewide consistency in rates.
- Need to look at some economies of scale to increase efficiency.
- Some functions such as credentialing should be done at the state level while some things need to be done more locally.
- How do we align clinical authority with fiscal authority?
- States that have separated those things have found that it is problematic.
- Put the service access and the funding authorization functions together to have clear accountability.
- Try to avoid having multiple layers. Need clarity and simplicity.

Should DHS have the authority to step in and manage the assignment of counties to regions if they have not done so by a given date?

- As long as it is done statutorily, that authority can be created but it would have to be written into the statute.
- 12 of the 13 AAAs have voluntarily come up with a plan to join into regions. What about the 13th?
- IDA will be taking competitive proposals (RFPs) from the AAAs to serve that area.
- A statutory framework for regions should allow DHS to assign counties to regions if they have not voluntarily joined a region by a specific date.
- It is important counties have a deadline and an imperative.

What discretion should the Department have to allow variances?

- What might be an allowable variance?

- Should DHS have statutory direction in how to make assignments based on DHS service areas or some other factors?
- The statute needs to consider ways DHS might intervene in the formation of regions.
- The legislature should set a date for the voluntary process.
- The State should have authority to step in if a region is falling apart.
- The State should have authority to function as a receiver.
- If DHS is to grant waivers to requirements, what, specifically, would be waived?
- Having a waiver could decrease the incentive for counties to work together and form regions.
- Don't want to be too arbitrary.
- Don't want to have requirements prevent logical formation.
- What about population numbers? Is 195,000 much different than 200,000?
- The longer it takes to form regions the less time there is for coordinating services and functions of the regions.
- Tending toward a preference for waivers under very limited conditions. Who would determine that?
- The bar could be a super majority of the MHDS Commission. That would be a pretty high hurdle.
- The legislature would have to address who at the county level makes the decision. By popular vote? By supervisor vote?

What should be in statute and what should be in rules?

- Could have DHS establish the size of regions by rules rather than statute, which would allow DHS to make exceptions to policy.
- Could also change population requirements as state population changes more easily.
- Overriding goal is what kinds of services need to exist in the region.
- The population size is a function of getting to the necessary size to support the array of services.
- DHS needs to have the authority to make regions happen by a date certain.
- An exception to policy would be something different from that.
- Put standards for regions in statute?
- Some small amount of discretion for DHS to make exceptions to policy.
- Does it really make sense to put strict population size into statute?
- In some areas you will have to expand the number of counties to meet the other requirements of the regions: CMHCs, FQHCs, inpatient psychiatric unit, etc.
- Should the MHDS Commission hear appeals for exceptions?
- Does DHS have the authority to specify that certain things are in the 28E agreements?
- The legislature would specify what agreements should contain.
- Specific requirements could be put into IA Code Chapter 331 for regional agreements.
- Probably not wise to change IA Code Chapter 28E unless it is to add a separate section for this purpose.
- What if a member wants to separate from a region after it has been in effect?

- DHS should have the authority to address it.
- Members will be bound by their 28E agreements.
- What are the implications for a region if one county wants out particularly if it is a "lynchpin" county?
- In the case of a lynchpin county, that may not be able to happen.

Consensus:

- DHS Director should have the authority to assign counties to regions by a date certain established by the legislature.
- Criteria for regions should be included in statute.
- Target population criteria, rather than absolutes.
- Money tied to approval of regional plan.
- Don't think there should be a lot of room for waivers/exceptions.
- 200,000 minimum number was based on the number of CMHCs, FQHCs, and inpatient units in the State.
- DHS Director should have authority to grant waivers on a very limited basis.
- Perhaps the population number should not be in statute or there should be a waiver from that requirement but not other requirements.
- Director should have discretion to grant waivers on population size.
- DHS should have the authority to intervene or name a receiver if necessary to assure continuity of care.
- What happens if a region is not able to comply with contract?
- DHS can intervene to ensure compliance.

Do we want to recommend a certain date?

- Counties will be putting budgets together for the next fiscal year so would want to be able to implement regions by beginning of the fiscal year.
- Date certain to form regions – January 1, 2013?
- Regions up and running – July 1, 2013?
- Need to start sooner. There is a lot to work through after they have formed.
- Recommend a year minimum?
- Voluntary decisions by July 1, 2012?
- Is it reasonable for regions to be formed by July 1, 2012 if the legislation is passed in April?
- DHS needs to be able to assign those who don't voluntarily align by January 1, 2013.
- To "go live" July 1, 2013, should have 28E agreements and regional plans in place by Jan. 1, 2013.
- The more time they have to realign the workforce, the smoother the transition will be.
- Who is going to provide technical assistance?
- The CPCs in the counties are going to have to do the work of getting together.
- Require memorandum of commitment by what date?
- Concern about consumers and their uncertainty about this process too; need to communicate to them that things will be okay.

- Supervisors and CPCs will be meeting together through ISAC on Friday, Nov. 18, 2011.
- It will be important for supervisors to hear from counties currently working together.
- Think regions will self select reasonably fast, but who is going to facilitate those new groups working together?
- Encourage legislature to include a provision for some short term TA contracts to help regions organize and get set up. This would help them meet a faster timeline.
- The reality has not set in yet with many supervisors.
- CPCs will need to play an intricate role.
- From the consumer standpoint, there will be a need to address transportation issues and how to get services where we don't have them now.
- Suggest regions can self designate anytime after legislation is passed.
- Then they can sit at table and work with DHS on implementation issues.
- By January 1, 2013 (date uncertain) all regions have to be formed with 28E agreements, governance and advisory boards in place.
- July 1, 2013, regions must be operational and performance agreements with DHS must be signed. Regions "go live".
- Recommend legislature put in money for TA. TA would go into effect when the region designates itself as an incentive to "join the club early".
- Concerned that the timeframe to too short.
- Many supervisors have very little to do with mental health.
- Supervisors have many other aspects of the job to deal with. Want time to do this right.
- It took CSS five years to come together.
- Have to get rules written and educate supervisors. Will need to "sell" the whole process.
- Think we need one more year (to July 1, 2014) to be fully operational.
- Where the money is coming from is a concern.
- We won't know what full operation is until we know what the money is. We can establish the dates, but the closer we get the more we will know.
- There needs to be a balance between keeping the momentum and taking enough time to do it right.
- Don't undervalue the importance of getting buy-in and trust at the beginning.
- If that takes more time it is time well spent.
- TA should start immediately to inform decisions on how counties group together.
- July 1, 2014 may be much more reasonable date.
- Groups that are starting to move right away will help inspire others to begin the process.
- Set target date for January 1, 2013.
- Make balance and pros and cons of timeline available to legislators.
- DHS would work with ISAC on planning regional meetings.

Recommended But No Consensus:
*Group will lay out pros and cons to the Interim Committee and let them consider the issue.

- Counties self select by January 1, 2012 with incentive to act earlier.
- Regions in place by July 1, 2013.
- Fully operational by July 1, 2014.

NEXT STEPS
Meeting #5 Agenda Topics:

Carryover items:

- Roles of Regions in Managing Medicaid Services and Interface with DHS

New items:

- Development of integrated recommendations
- Business and financial arrangements
- Relationships with other entities: state, managed care, other agencies (Child Welfare, Criminal Justice, etc.)

NEXT MEETING
The next Regional Workgroup meeting is scheduled for Tuesday, October 25, 2011 from 9:30 am to 3:15 pm in Room 103 at the Iowa State Capitol, 1007 E. Grand Avenue, Des Moines, IA.

- Prior to meeting we will send out summary of workgroup recommendations to date.
- Planning to have a telephone meeting on Oct. 19 from 10 to noon to discuss the draft recommendations before they are reported to the Interim Committee.

PUBLIC COMMENT

Comment: There are two areas that would threaten reform – financing and how the regionalization takes place. Senate File 525 sets out criteria to apply to regionalization and I do not see self-designation as a concept in the legislation. It seems to contemplate that at some point DHS has to say “this is a region.” Six of the criteria specified require DHS to apply discretion, for example, the capacity to deliver core services, establishing a financial reserve level, adequate financial resources, etc. You may want to get some directions about what you are going to recommend statutorily or by administrative rule. I don’t know what “financial reserve levels” means to county supervisors and you may want to get some legislative direction on that.

DHS Response: Some things have to be spelled out in legislation, some things may be provided by assurances, and there may be a difference between the early regional agreements and being fully operational.

For more information:

Handouts and meeting information for each workgroup will be made available at: http://www.dhs.state.ia.us/Partners/MHDSRedesign.html

Website information will be updated regularly and meeting agendas, minutes, and handouts for the six redesign workgroups will be posted there.